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The Drivers of Universal Health Care in South Africa

The Role of Ideas, Institutions and Actors

Rebecca Surender

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UNRISD, Palais des Nations
1211 Geneva 10, Switzerland

Tel: +41 (0)22 9173020
Fax: +41 (0)22 9170650
info@unrisd.org
www.unrisd.org

Contents

Acronyms

BHF	Board of Health Care Funders
CMAS	Council for Medical Schemes
HASA	Hospital Association of South Africa
NHI	National Health Insurance
OHSC	Office for Health Standards Compliance
PHC	Primary Health Care
SA	South African

Summary

To address problems of inadequate public health services, escalating private healthcare costs and widening health inequalities, the South African government has launched a radical new proposal to introduce a universal health system for all South Africans; National Health Insurance (NHI). While most attention has been thus far devoted to the economics and fiscal affordability of universal coverage, relatively less attention has been paid to wider challenges—in particular the important role played by key stakeholders tasked with designing and implementing the reforms.

This paper outlines the opportunities and challenges posed by the proposed NHI reforms in South Africa. It begins by explaining the country's current system of health care provision including its human resource structure, functions and cost implications. It then summarizes the deficits and limitations of the current two-tiered health system and discusses what NHI is trying to achieve within this context and how it hopes to address the problems. Finally, the paper examines the political and institutional challenges the reforms will face with a particular focus on the actors involved.

The findings suggest that the government will face considerable challenges to its proposed reform path and that the eventual design of the new system may have to be a compromised version of the system envisaged in the original Green Paper. In particular the government will face significant challenges in garnering the support of sections of the medical profession tasked with implementing the reforms.

Rebecca Surender is Associate Professor of Social Policy at the Department and a Fellow of Green Templeton College. She is the Director of the Centre for the Analysis of South African Social Policy (CASASP) at Oxford University, the first UK academic centre to undertake research exclusively on South African social policy.

1. Introduction

Access to health care for all South Africans remains a key challenge for the country's policy makers. Debates concerning the optimal reform path have increased in urgency in recent years and led to the proposed introduction of a far-reaching and ambitious reform strategy—a system of National Health Insurance (NHI) (RSA Department of Health 2011). Despite the term "insurance" the reforms aim to achieve a universal tax-funded system: comprehensive, integrated and available to all South Africans irrespective of income tax or insurance contributions. The proposal seeks to make health care a social right of citizenship rather than a market product and is in keeping with the current international drive for universal health care in developing countries (UN 2012; WHO 2005; UNRISD 2010). While there is consensus that universal health care is effective in improving coverage, health outcomes and reducing the prevalence of catastrophic and impoverishing health expenditure for the poor,[1] debate continues about the best mix of financing and service delivery mechanisms. Debates however do not concern only technical issues but reflect conflicts of interest between different stakeholders and are underpinned by ideological and normative disagreements about the appropriate goals of reform.

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2. The South African Health System: Past and Present

South Africa is a middle-income country with a GDP of US$ 420 billion (2010 estimate) and a population of 52.98 million people (Stats SA 2013). Its current health system is two-tiered in terms of financial and organizational structure and is highly inequitable in terms of access and quality. In order to understand the challenges facing the present system, it is necessary to place it in historical context.

Racial fragmentation of health care delivery during the apartheid era (1948–1994)

Apartheid, derived from the Afrikaans word for "apartness", signified the political policy under which the races in South Africa were subject to "separate development". It was a system of racial segregation enforced by the National Party governments of South Africa between 1948 and 1994, under which the rights of the majority non-white inhabitants of South Africa were curtailed and white supremacy and Afrikaner minority rule was maintained. For the purpose of implementing these policies, apartheid recognized four races: Bantu (or black African), Coloured (or mixed race), white and Asian (Shung King 2012).

[1] Chopra et al. 2009; Lagomarsino et al. 2012; Moreno-Serra and Smith 2012.

The country was subdivided into mainland South Africa, comprising four provinces, and 10 so-called "bantustans" or homelands ("self-governing" territories), to which large numbers of blacks were moved, according to their tribal origins. After "independent" status was conferred, homelands were constructed as nominally independent, mini-governments under the political domination of the central apartheid state. They were poorly governed by leaders who lacked political legitimacy for most black South Africans. They were chronically under-resourced, compounded by widespread corruption in their governments and lagged behind in all social services as compared to the "mainland" (Shung King 2012).

During apartheid, South Africa comprised an inequitable, racially fragmented system of health care delivery. Separate health departments were established in each of the homelands and became responsible for administering health care provision. Health funding and provision became further fragmented with the 1983 reforms, which restructured the system of institutionalized segregation and permitted Coloureds and Indians, alongside whites, to have their "own affairs" administrations. The administrative fragmentation of health delivery into several racialized departments reinforced inequities of funding allocations and service delivery. Access to public health care was now subject to the vagaries of new poorly organized, geographically isolated and under-resourced, racially-constituted health administrations.

Per capita health expenditure across the country and homelands differed by three- to four-fold between whites and blacks and huge inequities existed in health status and access to facilities between race groups, rural and urban dwellers, and rich and poor. Large hospitals absorbed most of the public health sector budget, despite the majority of health needs requiring primary-level and community-based care. A lucrative and poorly regulated private health sector covering less than 15 per cent of the (mainly white) population accounted for 60 per cent of total health care expenditure. A high prevalence of serious preventable health conditions directly linked to poverty, such as tuberculosis and malnutrition, afflicted the majority black population. The consequences became evident in the racially differentiated health status of the population once democratic rule was introduced in 1994, with black African, Coloured and Indian health outcomes significantly worse than those of whites (May 1998).

Table 1: Health indicators by race (1994)

Health indicator (1994)	African	Coloured	White	Indian
Infant mortality rate (per 1000)	54	36	7	10
Percentage of deaths 5 years and younger	20	19	12	13
Male life expectancy at birth (1000)	60	59	69	64